Individual Pricing Summary (IPS). A document that a contractor provides to the originating MTF/Claims Office which indicates the contractor's actions in pricing active duty claims.

Initial Payment. The first payment on a continuing claim, such as a long-term institutional claim.

Inpatient Care. *Care provided to a patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.*

Inquiry. Requests for information or assistance made by or on behalf of a beneficiary, provider, the public, or the Government. Written inquiries may be made in any format (letter, memorandum, note attached to a claim, etc.). Allowable charge complaints, grievances, and appeals are excluded from this definition.

In-System Care. *See "Network Care."*

Internal Control Number (ICN). The unique number assigned to a claim by the contractor to distinguish it in processing, payment, and filing procedures. It is the number affixed to the face of each claim received and will, at a minimum, include the Julian date of receipt and a five-digit sequence number assigned by the contractor. Each health care service record must have a unique internal control number. For records generated from claims, it will be the internal control number of the claim from which it was generated. For health care service records which are not generated from claims, it will be a unique number assigned by the contractor which will include the Julian date of the record's creation and a five-digit sequence number.

Line Item.

1. Each distinct occurrence, with the attendant charge, separately identified on a claim.

2. With respect to Health Care Service Records, up to fifty (50) occurrences submitted on the same record.

NOTE:

For purposes of (2), contractors have the option of restricting "line item" occurrences to those received in a single month. Also, for mental health services, each separate occurrence may be listed as a line item.

Machine-Readable Records/Archives. The records and archives whose informational content is usually in code and has been recorded on media, such as magnetic disks, drums, tapes, punched paper cards, or punched paper tapes, accompanied by finding aids known as software documentation. The coded information is retrievable only by machine.

Maximum Allowable Prevailing Charge. The CHAMPUS state prevailing charges adjusted by the Medicare Economic Index according to the methodology as set forth in the OPM Part Two, Chapter 4.

Medical Claims History File. (Refer to Beneficiary History File.)

Medicare Economic Index (MEI). An index used in the Medicare program to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expenses factors including malpractice, personnel costs, rent, and other expenses.

Microcopy. A photographic reproduction so much smaller than the object photographed that optical aid is necessary to read or view the image. The usual range of reduction is from 8 to 25 diameters. Also called microphotography.

Microfiche. Miniaturized images arranged in rows that form a grid pattern on card-size transparent sheet film.

Microfilm. A negative or a positive microphotograph on film. The term is usually applied to a sheet of film or to a long strip or roll of film that is 16mm, 35mm, 70mm, or 105mm in width and on which there is a series of microphotographs.

Microform. Any miniaturized form containing microimages, such a microcards, microfiche, microfilm, and aperture cards.

Military Treatment Facility/Claims Office. The Service office that will forward active duty claims to a contractor for pricing.

Military Treatment Facility (MTF). A military hospital or clinic.

Mobilization Plan - TRICARE. A plan designed to ensure the government's ability to meet the medical care needs of the *TRICARE*/CHAMPUS-eligible beneficiaries in the event of a military mobilization that precludes use of all or parts of the military direct care system for provision of care to TRICARE/CHAMPUS-eligible beneficiaries.

Monthly Pro-Rating. The process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for ten (10) months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

National Appropriate Charge Level. The charge level established from a 1991 national appropriate charge file developed from July 1986 - June 1987 claims data, by applying appropriate Medicare Economic Index (MEI) updates through 1990, and prevailing charge cuts, freeze or MEI updates for 1991 as discussed in the September 6, 1991, final rule.

National Conversion Factor (NCF). A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

National Disaster Medical System (NDMS). A system designed to ensure that the United States is prepared to respond medically to all types of mass casualty emergency

situations, whether from a natural or man-made disaster in the country or from United States military casualties being returned from an overseas conventional conflict. This system involves private sector hospitals located throughout the United States that will provide care for victims of any incident that exceeds the medical care capability of any affected state, region, or federal medical care system.

National Prevailing Charge Level. The level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during a 12-month base period.

Negotiated (Discounted) Rate. The negotiated or discounted rate, under a program approved by the Director, TMA, is the reimbursable amount that the provider agrees to accept in lieu of the usual TRICARE reimbursement, the DRG amount, the mental health per diem, or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

Network Care. Care provided by the network of Contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime Contractor as part of the total contracted delivery system. Thus *a "network* provider" is one who serves *TRICARE* beneficiaries by agreement with the prime contractor as a member of the *TRICARE* Prime network or of any other preferred provider network or by any other contractual agreement with the Contractor. "*Network* care" includes any care provided by *a "network* provider" or any care provided to a *TRICARE* Prime enrollee under a referral from the Contractor, whether by *a "network* provider" or not. *A "network* claim" is a claim submitted for "*network* care." (See the definition for "*Non-Network* Care.")

NOAA. The Commissioned Corps of the National Oceanic and Atmospheric Administration.

Nonappealable Issue. The issue or basis upon which a denial of benefits was made based on a fact or condition outside the scope of responsibility of TMA and the contractor. For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither TMA nor a contractor may review the action. Similarly, the need for a Nonavailability Statement, late claim filing, late appeal filing, amount of allowable charge (the contractor must verify it was properly applied and calculated), and services or supplies specifically excluded by law or regulation, such as routine dental care, clothing, routine vision care, etc., are matters subject to legislative action or regulatory rule making not appealable under TRICARE. Contractors will not make a determination that an issue is not appealable except as specified in the OPM Part Two, Chapter 6 and the *32 CFR 199.10.*

Nonavailability Statement (NAS). A statement issued by a commander (or designee) of a Uniformed Services medical treatment facility that needed medical care being requested by a *TRICARE* beneficiary cannot be provided at the facility concerned because the necessary resources are not available. Requirement for a non-availability statement is currently limited to inpatient treatment, but may, at the direction of the Assistant Secretary of Defense (Health Affairs), be extended to specific types of outpatient care. *TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option.*

Non-Claim Health Care Data. That data captured by the contractor to complete the required Health Care Service Record information for care rendered to *TRICARE*

beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

Noncurrent Records. Records that are no longer required in the conduct of current business and therefore can be retrieved by an archival repository or destroyed.

Non-DoD TRICARE Beneficiaries. These are *TRICARE*-eligible beneficiaries sponsored by non-Department of Defense uniformed services (the Commissioned Corps of the Public Health Service, the United States Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration).

Non-Network Care. Any care not provided by "*network* providers" (see definition of "*Network* Care"), except care provided to a *TRICARE* Prime enrollee by *a "non-network* provider" **upon referral** from the Contractor. *A "non-network* provider" is one who has no contractual relationship with the prime Contractor to provide care to *TRICARE* beneficiaries. *A "non-network* claim" is one submitted for "*non-network* care."

Non-Prime TRICARE Beneficiaries. These are *TRICARE*-eligible beneficiaries who are not enrolled in the *TRICARE* Prime program. These beneficiaries remain eligible for all services specified in the *32 CFR 199* and are subject to deductible and cost-share provisions of the *TRICARE* Standard Program.

Notice of Award. A communication by the Contracting Officer formally notifying the incoming contractor by letter, wire, or telephone of the contract award.

Operations Manual - (6010.49-M). The manual which provides the instructions and requirements for claims processing and health care delivery under *TRICARE* when these services are delivered under fixed-price, at-risk contracts for benefits and administration.

Out-of-Region Beneficiaries. *TRICARE*-eligible beneficiaries *who* reside outside of the region for which the Contractor has responsibility, but who receive care within the region.

Out-of-System Care. *See "Non-Network Care."*

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider who furnishes services or supplies to a *TRICARE* beneficiary and has agreed, by act of signing and submitting a *TRICARE* claim form and indicating participation in the appropriate space on the claim form, to accept the *TRICARE*-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the *TRICARE* allowance or requiring cost-sharing by the beneficiary or sponsor. All *network* providers MUST be participating providers.

Peer Review Group (PRG). A group of professional reviewers contracted with by the government to perform external peer review of the care provided under *TRICARE*. See the definition for "provider network."

Pending Claim, Correspondence, or Appeal. The claim/correspondence/appeal case has been received but has not been processed to final disposition.

Point-of-Service Option. *Option under TRICARE Prime which allows enrollees to self-refer for health care services to any provider in or out of the network. Point-of-Service claims are subject to deductibles and cost-shares (refer to definitions in this chapter) even after the*

Fiscal Year catastrophic cap has been met (refer to Policy Manual, Chapter 12, Section 10.1).

Preferred Provider Organization (PPO). An organization of providers who, through contractual agreements with the contractor, have agreed to provide services to *TRICARE* beneficiaries at reduced rates and to file *TRICARE* claims on behalf of the beneficiaries and accept *TRICARE* assignment on all *TRICARE* claims. The preferred provider agreements may call for some other form of reimbursement to providers, but in no case will an eligible beneficiary receiving services from a preferred provider be required to file a *TRICARE* claim or pay more than the allowable charge cost-share for services received.

Prevailing Charge. The charges submitted by certain non-institutional providers which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of the range establishes the maximum amount *TRICARE* will authorize for payments of a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge. The calculation methodology and use is determined according to the instructions in the OPM Part Two, Chapter 4.

Primary Care. Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for *TRICARE* beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

PRIMUS. An Army acronym for Primary Care for the Uniformed Services.

PRIMUS Clinics. Civilian-operated clinics that are designated as satellite clinics of military treatment facilities. They are under individual contract to the uniformed services and are funded directly by the services. The Navy has a similar civilian-operated clinic program under the heading of NavCare. *PRIMUS and NavCare clinics may serve as Primary Care Managers (PCMs) under the TRICARE Program.*

Priority Correspondence. Correspondence received by the contractor from the Office of the Assistant Secretary of Defense (Health Affairs), TMA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

Privacy Act, Title 5, United States Code, Section 552 a. A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably

possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

Processed to Completion (or Final Disposition).

1. Claims.

Claims are processed to completion, for workload reporting and payment record coding purposes, when all claims received in the current and prior months have been processed to the point where the following actions have resulted:

a. All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and checks and EOBs have been prepared for mailing to providers and beneficiaries, and

b. Payment, deductible application or denial action has been posted to ADP history.

2. Correspondence.

Correspondence is processed to completion when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.

3. Telephonic Inquiry.

A telephonic inquiry is processed to completion when the final reply is provided by either telephone or letter.

4. Appeals.

Final disposition of an appeal case occurs when the previous decision by the contractor is either reaffirmed, reversed, or partially reversed and the decision is mailed.

Program for Persons with Disabilities (PFPWD). The special program set forth in 32 CFR 199.5, through which family members of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically disabled over and above those medical benefits available under the Basic Program.

Profiled Amount. The profiled amount is the lower of the prevailing charge or the maximum allowable prevailing charge.

Program Integrity System. A system required of the contractor by the government for detecting overutilization or fraud and abuse.

Provider. A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with the *32 CFR 199*.

Quality Assurance Program. A system-wide program established and maintained by the contractor to monitor and evaluate the quality of patient care and clinical performance.

Receipt of Claim, Correspondence or Appeal. Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

Reconsideration. An appeal to a contractor of an initial determination issued by the contractor.

Records. All books, papers, maps, photographs, machine readable materials, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the United State Government under Federal law or in connection with the transaction of public business or appropriate for presentation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the government.

Records Management. The area of general administrative management concerned with achieving economy and efficiency in the creation, use and maintenance, and disposition of records. Included in the fulfilling of archival requirements and ensuring effective documentation.

Reference Material. Such items as the *32 CFR 199*, Operations Manual, Policy Manual, Procedural Code manuals, Diagnostic Code manuals, TMA Instructions, drug books, medical dictionaries and other materials, as appropriate to the needs of the operating unit.

Region. A geographic area determined by the government for civilian contracting of medical care and other services for *TRICARE*/CHAMPUS-eligible beneficiaries.

Relative Value Unit (RVU). Valuation or rating of physician services on the basis of relative physician resource inputs (work and other practice costs) to provide medical services. Specifically refers to relative physician work values developed by the Harvard University RBS study. (Only for Medicare RVUs given to contractors as part of the CMAC file for use in CMAC pricing, effective 5/1/92.)

Residual Claim. A claim for health care services rendered in an at-risk region to a patient who is not a resident of that region.

Resource Sharing Agreement. This is an agreement between the Contractor and individual military treatment facility commanders to provide or share equipment, supplies, facilities, physicians, nurses, or other trained staff who are under contract with, or employed by, the Contractor for work in MTFs for the purpose of enhancing the capabilities of MTFs to provide needed patient care to beneficiaries.

Resubmissions. A group of Health Care Service Records (HCSR) submitted to TMA to correct those Health Care Service Record claims and adjustments which generated edit errors when originally processed by TMA. These groups of records will be identified by the batch number and resubmission in the HCSR Header Record.

Retention Period. The time period for particular records (normally a series) to be kept.

Returned Claim. Any *TRICARE* claim, with attached documentation, containing less than sufficient information for processing to completion; a copy, or the original of, which must

be sent back for completion of required data, rather than retaining and developing by letter request, alone. A "Returned Claim" will normally be retained under contractor control in the "pending" claim inventory. A Coordination of Benefits claim returned to the claimant when OHI is known to exist, or other claims authorized for return "not under control", are not included as a "returned claim."

Risk Sharing. A contractual agreement between the government and the Contractor for sharing the financial burden or risk associated with the delivery of medical care services.

Routine Correspondence. Any correspondence which is not designated as Priority Correspondence.

Special Inquiries. Freedom of Information Act requests; Privacy Act requests; information requests by the news media; surveys, audits, and requests by Government agencies (including Department of Defense agencies and entities other than TMA) and Congressional Committees.

Specialty Care. *Specialized medical services provided by a physician specialist.*

Split Enrollment. Refers to multiple family members enrolled in TRICARE Prime *under different Lead Agents/contractors, including Managed Care Support (MCS) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.*

Standard CHAMPUS Program. *See "TRICARE Standard."*

Start Work Date. The date the incoming Contractor officially begins delivery of health care services, processing claims, and delivery of other services in a production environment, as specified in the contract.

Subcontracts. The contractual assignment of elements of requirements to another organization or person for purposes of *TRICARE*. Unless otherwise specified in the contract, the term also includes purchase orders, with changes and/or modifications thereto.

Third Party Liability (TPL) Claims. Third party liability (TPL) claims are those for services to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. Contractors and the government pursue repayment of care provided the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (42 U.S.C. paragraphs 2651-2653).

Third Party Liability (TPL) Recovery. The recovery of expenses incurred for medical care for personal injuries or illnesses on behalf of a *TRICARE* beneficiary from a third party source. Such recoveries can be made from a liable third party or his or her liability insurance (third party liability) or from a medical payments plan which covers the beneficiary for personal illness or injury. The contractor and the government will pursue recovery under the provisions of the Federal Medical Care Recovery Act (42 U.S.C. Paragraphs 2651-2653).

Transfer Claims. A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. *TRICARE* claims and attendant documentation must be referred to the appropriate contractor for processing. Notification must be sent to the claimant explaining the action taken, including the name and

address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

Transition. The process of changing Contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

Transitional Assistance Management Program. The Transitional Assistance Management Program (TAMP) was established to provide short-term transitional *TRICARE* and MTF benefits to certain former *TRICARE* beneficiaries.

Transitional Patients or Cases. Patients for whom active care is in progress on the date of a Contractor's start work date. If the care being provided is for covered services, the Contractor is financially responsible for the portion of care delivered on or after the Contractor's start work date.

Treatment Encounter. The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

TRICARE. *The Department of Defense's managed health care program for active duty service members, service families, retirees and their families, survivors, and other CHAMPUS-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and CHAMPUS. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions below).*

TRICARE Extra Plan. *A "preferred provider program." A TRICARE beneficiary not enrolled in TRICARE Prime may receive medical care from TRICARE network providers usually at a reduced cost under the TRICARE Extra Plan.*

TRICARE Prime Plan. A voluntary enrollment program offered by a government-selected Contractor that is at-risk for the benefit dollars. "Prime" must provide enhanced *TRICARE* benefits to all enrolled beneficiaries who live in areas where it exists. *The TRICARE Prime Plan* will usually be offered in military treatment facility catchment areas.

TRICARE Standard Plan. The current CHAMPUS Program specified by law (Title 10, United States Code); the *32 CFR 199*, the *TRICARE*/CHAMPUS Policy Manual (6010.47-M) and the Operations *Manual* (6010.49-M). TRICARE Standard includes the Basic Program and the Program for Persons with Disabilities (PFPWD).

Unbundled Billing. Unbundled, or fragmented, billing is a form of procedure code manipulation which involves a provider separately billing the component parts of a procedure instead of billing only the single procedure code which includes the entire comprehensive procedure.

Uniformed Services Family Health Plan (USFHP). *A government-contracted health plan that offers enrollment in TRICARE Prime to individuals who reside in the geographic service area of a USFHP designated provider who are eligible to receive care in military medical treatment facilities (except active duty service members). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE/CHAMPUS benefits. Designated providers under the USFHP were previously known as "Uniformed Services Treatment Facilities" (USTFs) and are former Public Health Service Hospitals. The service areas of the USFHP designated*

providers are listed at "http://www.usfhp.org" on the world wide web and under "USTF" in the Catchment Area Directory.

United States. "United States" means the fifty (50) states and the District of Columbia.

United States Public Health Service (USPHS). An agency within the U.S. Department of Health and Human Services which has a Commissioned Corps which are classified as members of the "Uniformed Services."

Unprocessable Health Care Service Records. Health care service records transmitted by the contractor to TMA and received in such condition that the basic record identifier information is not readable on the *TRICARE* data system, i.e., header incorrect, electronic records garbled, etc.

Utilization Review. A review of medical services by beneficiaries and providers to assess appropriateness and/or medical necessity. A quantitative evaluation method which may lead to development of quality of care issues, abuse issues, or, in some cases, fraudulent claims problems.

Visit.

1. Civilian Care Setting.

a. Those medical care procedures characterized by the professional examining and/or evaluating a patient and delivering or prescribing a care regimen. Professional visit procedures include CPT procedure codes 90000 - 90499, 90571 - 97799, 99175 - 99195, 99155 - 99156, each range inclusive except 90596, 90597, and 90599: and including emergency room visit procedure codes 90500 - 90570 and 90599.

2. Military Medical and Dental Treatment Facilities.

a. The definition of a visit as used in the Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual, DoD 6010.13-M (MEPRS Manual) applies. "Each time an eligible beneficiary presents himself to a separate organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation, counseling, medical advice: or is treated or observed in his quarters: and a signed and dated entry is made in the patient's health record or other record of medical treatment, then a visit is considered to have been completed and is countable: however, with the exception that consecutive clinic visits to specialty clinics, i.e., physical therapy and occupational therapy, will not require a signed and dated entry at each visit, unless there is a change in the prescribed treatment, or significant physical finding is evident. In all instances, however, an acceptable record audit trail will be maintained. For example, a clinic log or treatment card may be maintained as a source document to support an audit trail. Classification of a service as a visit will not be dependent on the professional level of the person providing the service (includes physicians, nurses, physician's assistants, medical specialists, and medical technicians)." The MEPRS Manual definition contains added instructions

related to the MTF counting of a "Visit." See Addendum A of this chapter for detail.

Wilford Hall Bone Marrow Project (Demonstration). A 5-year TMA/Air Force demonstration project authorized under the Demonstration authority (see definition of "Demonstration") to determine the feasibility of a centralized patient management system for allogeneic bone marrow transplants at Wilford Hall Medical Center. All allogeneic bone marrow transplant surgeries are under case management by the Wilford Hall medical staff.

Workday. A day on which full-time work is performed.